Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR HUSSEIN ELKOUSY
7401 SOUTH MAIN STREET
HOUSTON TX 77030-4509

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-0063-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed 23410 with modifier 22 this is for the revision of a previous rotator cuff repair which was torn due to recent work related injury. Modifier 22 was used based on the extent of injury and complexity of the service. We expect an additional 25% for the use of modifier 22 when it is documented. This bill needs to be reprocessed for additional payment."

Amount in Dispute: $473.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor seeks additional reimbursement through the use of -22 modifier for the operative repair of a rotator cuff problem. The operative report itself details a straightforward revision to a rotator cuff. There was nothing unusually extensive or difficult noted." "What is more, the surgeon has not shown that it was unusually extensive or difficult. Rather, there is a somewhat circular argument in a 7/18/11 letter from Juan Garcia indicating more payment is due because a -22 modifier was used in the billing."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 27, 2011	CPT code 23410-22-RT	$417.00	$00.00
	CPT code 23410-AS-22	$56.73	$0.00
TOTAL		$473.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 17, 2011
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

   Explanation of benefits dated August 5, 2011
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891-No additional payment after reconsideration.

   Explanation of benefits dated August 8, 2011
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891-No additional payment after reconsideration.

Issues

1. Did the requestor support the use of modifier -22? Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied additional reimbursement for CPT code 23410 based upon reason codes "CAC-W1-Workers compensation state fee schedule adjustment"; and "790-This charge was reimbursed in accordance to the Texas medical fee guideline".

   Code 23410 is defined as "Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute".

   Dr. Elkousy and Physician Assistant Juliette Zumwalt both used Modifier 22 on the bills. Modifier 22 is defined as "When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)."

   The requestor states in the position summary that "We billed 23410 with modifier 22 this is for the revision of a previous rotator cuff repair which was torn due to recent work related injury. Modifier 22 was used based on the extent of injury and complexity of the service. We expect an additional 25% for the use of modifier 22 when it is documented. This bill needs to be reprocessed for additional payment".

   The respondent states in the position summary that "The operative report itself details a straightforward revision to a rotator cuff. There was nothing unusually extensive or difficult noted." "What is more, the surgeon has not shown that it was unusually extensive or difficult".

   The requestor is seeking additional reimbursement of 25% above the MAR for code 23410. Review of the submitted Operative report does not support the requirements of modifier 22, specifically "increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required."

   As a result additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		5/17/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.